

**MASSACHUSETTS eHEALTH COLLABORATIVE
RFA FAQ #3**

Please submit RFA questions to RFAquestions@MAeHC.org
Please direct all other inquiries to Contact@MAeHC.org

APPLICATION PROCESS

- 74) Please provide further clarification regarding the “10 references/publications”. During the December 13th conference call, you stated these are “citations from public literature”. Do you want us to provide “citations from public literature” regarding the benefits, buy-in strategies, implementation approaches, community connectivity, etc. regarding electronic health records in general? It seems that applicants would provide the same or similar responses to this request. Or, do you mean “citations from public literature” about our hospital and therefore would include all forms of public literature (newsletters, newspapers, etc.)?

You may use up to 10 citations from secondary source literature to support your application. These citations could cover either of the areas you mention above.

- 75) Do you want the individual questions to be repeated in the response or can a paragraph(s) be developed for each of the covered areas (leaving out the question)?

You may leave out the question and organize your responses by question number.

- 76) Can a cover page precede the 5 pages of the RFA, the letters of support and page of references?

No, please do not include a cover page.

- 77) Aside from the selection criteria used, how is the application scored?

The primary criteria are as outlined in the RFA. We will not be using, or reporting, quantitative ratings for final determinations.

- 78) Is consideration taken for hospitals in communities within close proximity to Boston's major medical facilities?

No special consideration will be given for close proximity to Boston's or any other locality's major medical facilities.

- 79) How will you weigh the volume of specific populations and relationships with entities such as long term care facilities, assisted living facilities, VNAs, etc.?

Primary consideration will be given to physician offices, hospitals, laboratories, imaging centers, and pharmacies, as highlighted in the RFA. Other health care entities will be included based on community needs and available funding.

- 80) Do you consider the “project leader” to be the same as the “community leader?” Can these be two different individuals?

These can be two different individuals based on the community’s determination of its own needs.

- 81) We understand the application needs to be submitted via e-mail attachment. In addition to this, is it helpful to submit a paper backup, or would you prefer no other format be submitted?

Submission via email attachment will be sufficient. We will confirm receipt of your application via email.

- 82) Is it acceptable or encouraged that the credentials of the community advocate be presented as a separate addendum or should it be included in the body of the application.

You don’t need to elaborate too much on the community advocate’s credentials. A few lines in the body of the application will be sufficient.

- 83) Is it acceptable, or a violation, to have addendum(s) (i.e. the list of participating or supporting physicians) included with the application? Are you interested in this information at this time?

You may include a letter of support from all of the participating physicians or practices. We will be seeking more detailed information in the Phase 2 process.

- 84) Regarding letters from community leaders, the RFA references a mayor or Chamber of Commerce. Are members of the health care community, including physicians who are members of the applicant community, eligible to provide letters of support for an applicant?

Members of the health care community who are community leaders may submit letters of support. We leave it to the discretion of each community to determine which community leaders can offer letters that will strengthen an application.

- 85) Please elaborate on your thinking about proposals from mature networks. Would a project from a network that has installed basic EHR architecture at the majority of its practice sites, but seeks support to complete the interfaces necessary to have a completely paperless record (such as lab and radiology results reporting), as well as extend this architecture to additional practices in its network, be competitive? Do you view funding of a pilot with a more mature network as a way to examine measurable outcomes analysis regarding the difference automation makes?

As stated in the RFA, we will seek to balance a number of factors in the final pilot community selections. Among those will be health information technology adoption. We will use this variation to measure differences in both costs and benefits of differential adoption and connectivity.

- 86) Could you verify that there will **not** be funding to hospitals for CPOE except as part of a more wide-ranging initiative incorporating automation of the physician offices in the community?

As noted in the RFA, an aim of the pilot projects is to achieve near universal adoption of EHRs and to provide support for CPOE systems. The mix of this support will be determined by the particular circumstances of each community and the optimal allocation to achieve the pilot objectives. MAeHC will also be coordinating closely with the Massachusetts Technology Collaborative's CPOE efforts to ensure the most effective use of resources in each community.

- 87) How important is it that the MA EHR system support national data standards efforts such as those being pursued by the Public Health Data Standards Consortium and the National Health Information Infrastructure?

The exact data standards that will underlie MAeHC's connectivity infrastructure are still under consideration.

- 88) Would there be any benefit to including letters of support from national organizations such as the Public Health Data Standards Consortium?

No.

- 89) Who will be making the final decision on which pilots will be selected?

The Pilot Selection Committee will be drawn from the Executive Committee of MAeHC. Dr. David Bates will be the Chair and Micky Tripathi will be the Vice-Chair. Individuals who are participating in an application or have other direct conflicts of interest will be asked to recuse themselves from the Committee.

- 90) What characteristics will the selection committee be looking for in a community? Is size a factor?

As stated in the RFA, the committee will be seeking to balance a number of factors across the 3 communities, including but not limited to: size, variety in physician practice sizes, geography, and technological maturity.

- 91) Is there any budgetary information that is needed in this process?

As part of phase 2 of the selection process, MAeHC will work closely with the potential communities on a budgetary assessment and plan. No information is required from any applicant at this time.

- 92) What are some of the primary areas for lessons learned that MAeHC hopes to gain from these pilots?

Areas include, but are not limited to, potential barriers, key success factors, and cost and quality benefits.

- 93) Are there negatives associated with a community that crosses state lines?

This is not disqualifying, so these communities are encouraged to submit an application. Specific issues arising from these situations will have to be addressed on a case-by-case basis.

- 94) Would a community of 250-300 physicians be reasonable in terms of what the grant would support?

We will balance a number of criteria as stated in the RFA and fund what we can within our budget constraints. The budgetary requirements will be determined based on an in-depth examination of the community's requirements.

- 95) Will there be a third informational call?

No, however, we will continue to respond to questions via the questions mailbox (rfaquestions@maehc.org) through January 21.

COMMUNITY DEFINITION

- 96) From RFA 1d question 1): How do we accurately define how many patients (individuals) are covered by the provider "network" participating in this project? Do we include population statistics, major health plan enrollment numbers for a geographic area, primary care physician office active patient numbers, etc.? How do we include populations of patients that visit our area from outside the network or community for specialty care?

We realize that this number is typically not readily available and thus will have to be estimated using a variety of data sources, such as those listed above. We are trying to get a rough idea of the population covered and do not expect the figures to be highly accurate. There are several ways to address this issue. One approach would be to present the populations of towns or geographic areas. Another would be to combine major plan numbers from several payers. A third would be to sum primary care active numbers. One problem will be double-counting of individuals across provider settings, and you should describe how you dealt with this. Overall, we are primarily interested in capturing encounters across the continuum of care for patients who receive the majority of their care in the "network", so please separate out specialty visits for patients who receive primary care outside of the "network".

There will be variety in the approaches taken to make these estimates, which will be driven by the data available in each community. For this reason, please describe the approach (or approaches) you ultimately use to estimate the figures you present.

- 97) From RFA 1d question 2): How do we accurately define how many patient annual patient visits? We have data available on visits to physician offices and we have data from our insurers generated by claims. To clarify our question, an example: an individual sees his/her PCP at which time he orders additional tests that generate more claims, would that be counted as one visit or do we count every encounter (i.e. lab tests, etc)?

Please provide as much of a detailed breakout as possible, and at a minimum, please separate physician visits from other types of encounters. We would prefer to count a physician visit and the associated lab tests as one visit if you can do so.

- 98) Question 1D asks “approximately how many patient visits do you have annually”? How are you defining “patient visits”? Do you want all inpatient and outpatient encounters? Or, do you just want outpatient visits? If it is only outpatient visits, do you just want “an office visit with a physician” or do you want all physician encounters (which could include procedures in the office)?

Please provide inpatient admission and outpatient visit counts. For outpatient, please separate physician visits from other types of encounters (see question #75).

- 99) Can you define a “community” as a disease-specific community (such as cancer), or service-specific community (such as Med-Flight)?

For the pilot projects, we are seeking “communities” that cut across multiple areas of care, especially primary care. Thus, applications focused on particular segment of service or a narrow set of diseases or conditions will thus not be considered for the pilot projects. They will, of course, be considered as part of a larger application covering a broader spectrum of care. Finally, please remember that each application needs to include at least one acute-care hospital as listed in appendix B of the RFA.

HARDWARE/SOFTWARE SUPPORT

- 100) When discussing a Community EMR are you talking about: 1) Remote access by physicians and other community providers to a hospital based EMR (where physician office data and community provider data is maintained separately within their own offices)? 2) Remote Access in both directions between hospitals, physician offices and other community providers (where data is still maintained separately by each entity but shared through remote access)? 3) A truly joint EMR with a common Master Patient Index created and maintained by all community participants (Hospital, Physician, and other providers)? 4) Other.

The RFA does not refer to a “community EMR.” The RFA does discuss community-wide implementation of EHRs, which refers to adoption of stand-alone EHR systems in health care delivery settings. The RFA also refers to data exchange capability among these stand-alone systems. The technology and architecture for achieving this exchange capability is still under consideration.

- 101) Is the end objective for the EHR one standardized record available to all facilities within the network?

The pilot will invest in stand-alone systems and connection infrastructure to allow data exchange. The details of the data exchange component are still under consideration.

- 102) Will the EHR records require the same information as the state for each patient encounter?

The baseline clinical requirements of the EHRs that the Collaborative will support are still under consideration.

- 103) How will a community uniquely identify each patient in multiple systems? How will we create a community-wide master patient index?

Patient identification across settings is part of the connectivity infrastructure that MAeHC will provide. The exact technology and architecture for this capability are still under consideration.

- 104) Healthy People 2010 Objective 23-3 states "Increase the proportion of all major national, State, and local health data systems that use geocoding to promote nationwide use of geographic information systems (GIS) at all levels," -- 90% is the Objective's target. How will geocoding and more fundamentally address standardization be included in the MA EHR considerations?

The clinical and functional requirements of the EHR systems that the Collaborative will support are currently under consideration.

- 105) What does MAeHC envision these pilots looking like after a set period of time?

There will be a great deal of variation on how pilots will look, however, a reasonable example might be that, within 1 to 2 years, there will be 85% of providers using an electronic medical record, the hospital will be using CPOE, and there will be some clinical data exchange within the community.

- 106) How will the development of national data standards be accounted for? And how will that play into the vendor certification process?

There are MAeHC working groups addressing these issues and interdependencies and they will stay in close touch with any national developments and include them in this process.

- 107) How many vendors will be available to select from?

We believe that adoption will be maximized by offering choices. Thus, we anticipate that each community will have multiple vendors to choose from. Which vendors, and how many will be offered, are still under consideration and will be partly shaped by individual community preferences.

FUNDING

- 108) You have commented that additional sources of funds will be looked upon favorably. Do you encourage financial commitment from participating providers? Will philanthropic support enhance an application?

Any financial commitments made by any stakeholders that align with the pilot project's objectives will be favorably looked upon. There is no requirement for financial commitment, however. Also please see the Funding section of RFA FAQ #1.

109) Will there be assistance, labor or financial, available for productivity drop-offs during the implementation process?

Areas of assistance will be addressed during the budgetary process based on community needs and budget constraints. A key part of the pilots will be to provide support to maximize the likelihood of success, and removing barriers to adoption thus will be an important priority. We will work with each community to develop programs that most effectively accomplish this objective.

110) Will any additional money that is raised be allocated to the 3 chosen pilot communities or to fund additional communities?

As part of our mission to spearhead the creation of a state-wide health infrastructure, we will be continuously seeking other sources of funds to fund other communities beyond the 3 pilot communities as rapidly as possible. In addition, we will to the greatest extent possible provide non-financial support to any community within the Commonwealth.
